cyst, which was not connected with the thyroid gland. This method hastens the process of suppuration, and does not seem to be attended with any inconveniences, when precaution is taken to avoid wounding the substance of the thyroid gland.

The *extirpation* of the entire sac may be adopted with advantage, when the cyst is small, superficially seated, and not firmly adherent to the thyroid gland, or to any other of the neighbouring important parts.

M. Jobert practised it with success in the case of a woman, 30 years of age, in whom the tumour was of the size of a hen's egg, and was smooth, hard, and so resisting that it communicated no feeling of fluctuation; the wound healed up by the first intention, the twisted suture having been employed to retain its lips together. But we must refer our readers, who may wish to make themselves acquainted with the particulars of the various cases on record, to the original paper of MM. Fleury and Marchessaux, and will now extract only the following conclusions, which they have deduced from their inquiries.

1. The encysted tumours of the neck may be arranged, according to their anatomical position and relations, in two classes—one comprising such as are developed in the substance of the thyroid gland, and the other, all those which are developed in the cellular tissue of some portion of the neck.

2. The *first* set seems to be attributable to the hypertrophy of one or more of the cells of the thyroid gland, and, if so, cannot be regarded as encysted tumours, in the strict sense of the phrase; whereas in the *second* set, the sac of the tumour is a genuine cyst of a sero-mucous nature.—(*Delpech.*)

3. This distinction is important both in a diagnostic and in a therapeutic point of view.

4. The tumours of the first class may be readily mistaken for genuine goitre; and those of the second for chronic abscesses, lymphatic swellings, or aneurismal swellings.

5. Encysted tumours of the neck, whatever be their nature, should never be left to Nature; they always require surgical assistance for their dispersion.

6. Among the various methods of treatment, which have at different times been proposed, that of nearly puncturing, and that of injecting the sac, appear to be the least trustworthy and advisable. The employment of a seton, after a free incision has been made, has been found useful in tumours of the first class, by inducing and keeping up a long and abundant suppuration, and thereby causing a melting down of the hypertrophied and swollen tissues; also in all cases where the cyst was multilocular, by giving a free discharge to the contents, and preventing an accumulation in any of the cells. On the whole, it may be laid down as a therapeutic principle, that the incision of the swelling and the subsequent employment of some means to establish suppuration in the cyst, seem to be the best method of treating almost every encysted tumour of the neck, whatever be its origin or seat.

The complete extirpation of the sac may be recommended when this is not very large nor closely adherent to the surrounding parts.—*Med. Chirurg. Rev.* and *Archives Générales de Méd.*, Aug. 1839.

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33. *Application to Blistered Surfaces.*—Sir Benjamin Brodie employs the following preparation as an application to blistered surfaces when they become irritable and painful; ℞. Creta pp. Ol.Oliv. āā ʒv; Aq. Ros. ℥ij. *Lancet.*

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34. *Dislocations of the Humerus and Fractures of the Head and Neck of that Bone.* The last number of Guy's Hospital Reports contains an essay of Sir Astley Cooper, upon dislocations of the os-humeri and on fractures of the head and neck of that bone, which, as being of a practical character, and emanating from one who at the same time that he is the acknowledged head of European surgeons, has devoted himself in a particular manner to the study of luxations, and fractures about the joints, is entitled to especial attention. Since the publication of his last work on luxations of the shoulder, several cases of dislocations on the dorsum scapulæ have come to the knowledge of Sir Astley, as also an example of

the post mortem appearances presented in these cases. Backward dislocations of the head of the humerus are, he observes, usually produced by a violent push of some opposing body while the arm is advanced, and probably in these cases the posterior part of the capsular ligament is torn, permitting the escape of the bone upon the dorsum of the scapula and its inferior costa. The principal symptoms which make known the existence of this accident, are a depression below the acromion, a projection formed by the head of the humerus behind the glenoid cavity, which when the elbow is rotated will be found to obey its motions, and the close approximation of the elbow to the side.

The common mode of reduction in such cases, is to fix the scapula and draw the arm outwards from the body, but finding the reduction to be slowly and with difficulty effected by this means, Sir Astley employed the following method with success. The case was one of twenty-three days standing occurring in a gentleman who had received his accident in a scuffle. He says, "I placed the patient upon a chair, and bending his elbow at right angles, I raised his arm, and carried it behind his neck, so as to bring the hand across the back of the neck to the opposite shoulder; then forcing the elbow back, and pressing upon the head of the bone, I pushed it under the inferior costa of the scapula, and it instantly returned into the glenoid cavity." Other means however will succeed; in a case at Guy's Hospital, the patient was placed in a chair with the knee in the axilla, while extension was made by an assistant from the wrist, and the bone was reduced. In another instance, it is stated that Mr. Dunn, easily succeeded by fixing the scapula and extending from the wrist in the usual mode of reducing a dislocation into the axilla. Dr. Physick, we may add, in one instance succeeded in effecting the reduction, by making extension and counter extension in the usual manner, at the same time that the head of the bone was pressed towards the glenoid cavity. The method above described as adopted by Sir Astley, will not always succeed as he shows by a case communicated to him by Mr. Key, which fell under the observation of that gentleman in August last in conjunction with Mr. Whittaker. The patient was a very stout man who received his injury by a fall upon his shoulder. "At first," says Mr. K. "we placed our patient on a chair and while Mr. W. fixed the scapula, I carried the elbow upwards and backwards, in order to throw the head of the bone forwards into the glenoid cavity, but to no purpose. All that we gained by this measure, was a slight advance of the bone and reducing him to a state of syncope. In this state we laid him upon his back; and fixing his scapula by the heel in the axilla, drew the arm downwards; and by extension continued for a minute or two, succeeded in reducing it."

The case in which Sir Astley had the rare opportunity of witnessing the post-mortem appearances after this accident, was that of a person ætat. 52, who was subject to fits of epilepsy, in one of which, occurring while in bed, his shoulder was dislocated by muscular action alone, it having been well ascertained that he neither fell from his bed, nor struck his shoulder during the fit. Another peculiarity of this case was, that the head of the bone could be by extension drawn into its natural situation, but so soon as the force ceased to be applied, it slipped back upon the dorsum scapulæ. Although the patient lived seven years after the occurrence of this accident, he never recovered the use of the limb. The appearances presented on dissection are thus described:—"The head of the os-humeri was placed behind the glenoid cavity of the scapula; and it rested upon the posterior edge of that articulatory surface, and upon the inferior costa of the scapula, where it joins the articulation. When the scapula was viewed anteriorly, the head of the os humeri was placed in a line behind the acromion, but below it; and a wide space intervened between the dislocated head of the bone and the coracoid process, in which the fingers sunk deeply towards the glenoid cavity of the scapula.

"When viewed posteriorly, the head of the os humeri was found to occupy the space between the inferior costa and spine of the scapula, which is usually covered by the infra-spinatus and teres-minor muscles. The tendon of the subscapularis muscle and the interior portion of the capsular ligament had been torn at the insertion of that muscle; but the greater part of the posterior portion of the capsular ligament remained, and had been thrust back with the head of the bone, the back part of which it enveloped.

"The supra-spinatus muscle was put upon the stretch; the subscapularis diminished by want of action; and the infra-spinatus and teres minor muscles were shortened and relaxed, as the head of the bone carried their insertions backwards. The tendon of the long head of the biceps muscle was carried back with the head of the bone, and elongated; but it was not torn.

"As to the changes in the bones, the head of the os humeri and the outer edge of the glenoid cavity of the scapula were in direct contact, the one bone rubbing upon the other when the head of the os humeri was moved; and this accounted for the sensation of crepitus at the early period of the dislocation, as there was no fracture. The glenoid cavity was slightly absorbed at its posterior edge, so as to form a cup, in which the head of the bone was received; and this latter bone, and the articular cartilage, had been in some degree absorbed where it was in direct contact with the scapula, as well as changed by attrition during the seven years the patient lived.

"The surface of the original glenoid cavity, instead of being smooth and cartilaginous, was rough and irregular, having elevations at some parts, and depressions at others."

Of Fractures of the Head and Neck of the Os Humeri.—As these injuries often so closely resemble dislocation, as to lead to errors in their diagnosis and treatment, Sir Astley has thought it well to bring together the observations which in the course of his long and extensive practice, he has had an opportunity of making concerning them. These accidents are of three kinds:

1. Dislocations of the os humeri into the axilla, with fracture and detachment of the head of the bone, which is thrown on the inner side of the inferior costa of the scapula. This accident is always the result of great violence to the part, and the signs of it resemble closely the symptoms of simple dislocation of the head of the humerus into the axilla. In order to distinguish it from luxation, it must be recollected, 1st. That the depression of the shoulder is less marked than in that accident, the end of the shaft of the bone filling the glenoid cavity. 2d. That upon raising the arm the head of the bone can be felt in the axilla, though it does not roll upon rotating the elbow; 3d. That a grating sensation, and sometimes a distinct crepitus can be felt from the neck of the bone rubbing against the glenoid cavity. 4th. That the broken extremity of the humerus is drawn forwards towards the coracoid process, but that it is readily pushed back into the glenoid cavity from which it easily again slips forwards. 5. That the arm measured from the acromion to the elbow is shorter than that of the opposite side. In the treatment of this fracture, all that can be done is to bring the broken shaft of the bone, into the glenoid cavity and retain it there, where it will form a useful joint, though some of the motions of the arm will be lost.—To effect this purpose a pad must be placed in the axilla, a clavicular bandage used and the fore arm supported in a sling. Of cases of this nature, Sir Astley has seen, as he believes, many in the living and has dissected three of them, and can consequently describe them as they appeared on dissection as well as give the appearances they present during life. The post-mortem appearances of one of these cases we shall transcribe:

"The deltoid, teres-major, and coraco-brachialis, did not appear altered.—The supra-spinatus was somewhat wasted, as was the teres-minor; and their colour was fainter than natural. The infra-spinatus was put upon the stretch.—The subscapularis passed over the head of the bone, and adhered to its cartilaginous surface.

"The fractured neck of the shaft of the os humeri was seated in the glenoid every other part was entire.

"The head of the os humeri had been broken off; and was found in the axilla, behind the coracoid process of the scapula, and it was strongly united to the inner side of the scapula.

"The capsular ligament had been torn, under the subscapularis tendon; but the cavity of the scapula, widely separated from the head of the bone; and the broken os humeri formed a new and good articulation with the glenoid cavity, with a capsular ligament over it, which was in part newly formed. A ligamentous matter passed from the broken end of the os humeri to the inner surface of the glenoid cavity of the scapula.

"The edge of the glenoid cavity remained; but its surface was rather ligamentous, than smooth and cartilaginous.

"The greater tubercle of the os humeri had become enlarged; the tendon of the biceps remained in the biciptical groove; and the tubercles were connected with the broken extremity of the shaft of the os humeri, and not with its head."

In the second kind of fracture through the neck of the bone, at the tubercles, the head of the humerus is broken off, but it remains in the glenoid cavity.—This fracture occurs at the anatomical neck of the bone, at the part at which the capsular ligament is fixed, and where in young persons the epiphysis is placed. Fracture at this point is most frequently met with in children, and is usually the result of falls upon the shoulder. The accident, Sir Astley has known to have been mistaken for dislocation; from this however it may be distinguished by the following symptoms: 1st. The shoulder is not sunken as in luxation. 2d. The end of the broken bone is felt at the coracoid process, and this is supposed to be the head of the humerus, but with care the head of the bone can be felt filling the glenoid cavity: 3. By extension the projection is removed, but immediately reappears when the extension is removed: 4. Motion of the shoulder is painful, and the elbow is with difficulty removed from the side. In old persons fracture through the anatomical neck of the bone is comparatively rare. The best method of treatment consists in the application of splints to the front and back of the arm and the use of a clavicular bandage with a pad in the axilla. In a case which occurred to Mr. Tyrrell, he could not succeed in removing the deformity or in keeping the bone in its place, until the arm was raised and supported at a right angle with the side, by means of a rectangular splint, a part of which rested against the side, while the arm reposed upon the other part. An instance of what the writer of this analysis believes to be an example of this accident, very recently came under his notice. The patient was a young man who had fallen down the hold of a ship at Rio Janeiro and struck his shoulder. Great swelling and pain followed, and as the vessel to which he was attached, sailed the day after his accident, no treatment other than that of keeping the arm in a sling, was pursued. Upon his arrival in Philadelphia, six weeks afterwards, the shoulder presented the following appearances. Measurement of the arm from the acromion to the elbow showed it to be shorter than that of the opposite side: the arm could not be lengthened by extension, and the elbow could be brought down in close contact with the side: the shoulder had not lost its natural rotundity; but an irregular projection existed at its upper front part which rotated with the arm. The parts allowed of considerable motion, and there was every reason to believe that a very useful though deformed articulation would eventually be formed.

In the third kind of fracture of the shoulder, the bone is fractured in its surgical neck, viz. between the tubercles and the insertion of the pectoralis major, coraco-brachialis, latissimus dorsi, teres-major and the deltoid muscles. In this fracture there is no depression under the acromion, the head of the bone being in its cavity, but the fractured extremity of it is drawn upwards and forwards under the pectoral muscle. The elbow may be moved more freely in all directions than in the other injuries about the shoulder, though all motion of it is accompanied with much pain.

In the treatment of this case, splints, the clavicular bandage and the pad in the axilla are required, and Sir Astley particularly recommends that the arm be permitted to hang by the side, unsupported at the elbow so as to let the weight be a constant source of extension. G. W. N.

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35. *Extirpation of an Encephaloid Tumour of the Testicle weighing nine pounds.* M. Ph. Boyer, Surgeon to the Hôpital St. Louis, presented to the Academy of